DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**
**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 01-02

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 1-1-01

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY 01 $ (4,313,000)
b. FFY 02 $ (5,750,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 8, 25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 8, 25

10. SUBJECT OF AMENDMENT:
**Outpatient Hospital**

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
Ann Patla

13. TYPED NAME: **Ann Patla**

14. TITLE: **DIRECTOR**

15. DATE SUBMITTED 1/8/01

16. RETURN TO:

**ILLINOIS DEPARTMENT OF PUBLIC AID**
**201 SOUTH GRAND AVENUE, EAST**
**SPRINGFIELD, IL. 62763-0001**
**ATTENTION: John Rupcich**

17. DATE RECEIVED:

19. EFFECTIVE DATE OF APPROVED MATERIAL

21. TYPED NAME: Cheryl A. Bruno

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92) *Instructions on Back*

RECEIVED
JAN 10 2001
DMIO - IL/IN/OH

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE BASIS FOR REIMBURSEMENT

07/99

E. For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amount described in subsection D. above, multiplied by a factor of two. However, such rates shall be no lower than the rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

==01/01

F. Reimbursement for each APL group described in subsection b.i. shall be all-inclusive for all services provided by the hospital., ~~regardless of the amount charged by a hospital~~. No separate reimbursement will be made for ancillary services or the services of hospital personnel. Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician providing direct patient care who is salaried by the hospital, and occupational or speech therapy services provided in conjunction with rehabilitation services as described in subsection .b.i. of this Section. For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.

07/99

G. The Department of Public Aid will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered APL groups as defined in this section. The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in a hospital setting. All groups that may be reimbursed to an ASCT are defined in the Department's hospital handbook and notices to providers. Reimbursement levels shall be the lower of the ASTC's usual and customary charge to the public or an all inclusive rate for facilty services, which shall be 75 percent of the applicable APL rate.

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

payments under Section 1.j. of this attachment, if it is believed that technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification under Section 1.j. of this attachment, and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request or review.

==01/01 l. Notwithstanding the provisions set forth in Chapter I, Section b., Ambulatory Surgical Treatment Centers, the changes described in this Section l., shall be effective January 1, 2001. Payments for hospital outpatient services and ambulatory surgical treatment services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals described in Chapter II.C.8, or children's hospitals described in Chapter II.C.3.